NetSolutions

Common Plan Setups
And
Reimbursement Tables
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ABOUT PLAN SETUPS

This document lists some of the more common plan process setups. As in other parts of NetSolutions, the plan processes are extremely flexible. While there are many methods in the system, quite a few of them deal specifically with state Medicaid plans and their quirks, so after those are taken out of the loop, we end up with a much smaller list with which to concern ourselves. When setting up new Plan Process tables, there are a few things to remember:

- The sequential order of the methods does matter – the C methods would normally be at the top, with the W methods at the bottom.
- When adding new methods, make sure to check only the options that are necessary. For example, if you don’t have Apartments, don’t have a checkmark on them.
- In general, you won’t have the same thing checked on more than one method of the same type. For example, you wouldn’t have a C005 with Beds checked and a C001 with Beds checked. One exception to this would be multiple C008 methods on a Medicaid plan.
- The W methods should have checks to match the methods above them. For example, don’t have a checkmark on Apartments on the W method if there is no Apartment checked in any of the methods above it.
ROOM AND BOARD PLANS

**Gross Charges**

**C001** Beds, Apts, Assist Living, Leaves, Ancillaries, Reserves

This is normally used for Private Pay plan or plans that pay Gross Charges. This setup would be used on a Most or Few type plan. It will charge items at the gross price and there will be no write-offs.

**Rate by Level and Co-insurance**

**C005** Beds
**C001** Ancillaries
**P004** Co-Pay - Beds
**W001** Beds, Ancillaries

This is normally used for the Medicare A PPS plan or plans that pay rates by level and involve co-insurance with a set amount. This plan would not pay for any leaves. This setup would be used on an Inclusive type plan. It will charge per-diem at the reimbursement rate and push the co-insurance to the co-insurer specified. The reimbursement rates are on Plan Items.

**Rate by Level and Co-insurance varies by Resident**

**C005** Beds
**C001** Ancillaries
**P020** Co-Pay - Beds
**W001** Beds, Ancillaries

This is normally used for plans that pay rates by level and involve co-insurance where the co-insurance varies by resident. This plan would not pay for any leaves. This setup would be used on an Inclusive type plan. It will charge per-diem at the reimbursement rate and push the co-insurance to the co-insurer specified. The reimbursement rates are on Plan Items. The P020 will need a default rate entered on the Plan Process Detail, and the actual co-insurance rate will be entered on the resident’s reimbursement table.

**Rate by Level and Private Portion**

**C005** Beds, Leaves
**C001** Ancillaries
**P007** Private Portion - Beds, Leaves
**W001** Beds, Leaves, Ancillaries

This is normally used for a Medicaid plan or plans that pay rate by level and involve private portion. This setup would be used on an Inclusive type plan. It will charge per-diem at the reimbursement rate and push the private portion amount to the co-insurer specified. The reimbursement rates are on Plan Items.
Negotiated Rate per Resident

C010  Beds, Leaves
C001  Ancillaries
W001  Beds, Leaves, Ancillaries

This is normally used for a plan that has a negotiated rate per resident and no co-pay. This setup would be used on an Inclusive type plan. It will charge per-diem at the reimbursement rate. The reimbursement rates are normally on the Reimbursement table. If there is no rate on the table, the system will look to the plan item for a rate. If there is no plan item or plan item rate, it will use the gross price of the room item.

Negotiated Rate per Resident with variable co-pay

C010  Beds, Leaves
C001  Ancillaries
P020  Co-Pay - Beds
W001  Beds, Leaves, Ancillaries

This is normally used for a plan that has a negotiated rate per resident with co-pay that varies per resident. This setup would be used on an Inclusive type plan. It will charge per-diem at the reimbursement rate and push the co-insurance to the co-insurer specified. The reimbursement rates are normally on the Reimbursement table. If there is no rate on the table, the system will look to the plan item for a rate. If there is no plan item or plan item rate, it will use the gross price of the room item. The P020 will need a default rate entered on the Plan Process Detail, and the actual co-insurance rate will be entered on the resident’s reimbursement table.

Contracted Rates by Facility

C005  Beds, Leaves
C001  Ancillaries
W001  Beds, Leaves, Ancillaries

This is normally used for a plan that has contracted rates for the facility. This setup would be used on an Inclusive type plan. It will charge per-diem at the reimbursement rate. The reimbursement rates are on the Plan items.

One Rate by Facility

C002  Beds, Leaves
C001  Ancillaries
W001  Beds, Leaves, Ancillaries

This is normally used for a plan that has flat rate per diem for the facility. This setup would be used on an Inclusive type plan. It will charge per-diem at the reimbursement rate. The reimbursement rates are on the C002 method.
Percentage of Charges and Remainder Written Off

C003    Beds, Leaves, Ancillaries
W001    Beds, Leaves, Ancillaries

This is normally used for a plan that pays a percentage of gross charges and writes-off the remainder. This setup would be used on a Most type plan. It will charge items at the gross price, and do a write-off for percentage not paid. The reimbursement percent is on the C003 method.

Percentages of Charges with Remainder passed to next payor

C003    Beds, Leaves, Ancillaries
K001    Beds, Leaves, Ancillaries

This is normally used for a plan that pays a percentage of gross charges and the remainder can be passed off to another payor. This setup would be used on a Most type plan. It will charge items at the gross price, and the remainder is passed to the next payor who will accept the charges. The reimbursement percent is on the C003 method.

One Rate per Facility and Remainder Passed to Next Payor

C002    Beds, Leaves
C001    Ancillaries
K001    Beds, Leaves, Ancillaries

This is normally used for a plan that pays a flat amount per diem and the remainder can be passed off to another payor. This setup would be used on a Most type plan. It will charge per diem at the reimbursement rate and the remainder is passed to the next payor who will accept the charges. The reimbursement amount is on the C002 method.

Rate Negotiated by Resident and Remainder passed to Next Payor

C010    Beds, Leaves
C001    Ancillaries
K001    Beds, Leaves, Ancillaries

This is normally used for a plan that pays a negotiated per diem and the remainder can be passed off to another payor. This setup would be used on a Most type plan. It will charge per diem at the reimbursement rate and the remainder is passed to the next payor who will accept the charges. The reimbursement rates are normally on the Reimbursement table. If there is no rate on the table, the system will look to the plan item for a rate. If there is no plan item or plan item rate, it will use the gross price of the room item.
**Rate by Level and Co-insurance is a % of the reimbursement rate**

- C005  Beds
- C001  Ancillaries
- P028  Co-Pay - Beds
- W001  Beds, Ancillaries

This is normally used for plans that pay rates by level and involve co-insurance where the co-insurance is a percentage of the reimbursement rate. This plan would not pay for any leaves. This setup would be used on an Inclusive type plan. It will charge per-diem at the reimbursement rate. The reimbursement rates are on Plan Items. The P028 will need a default rate entered on the Detail, and the actual co-insurance rate will be entered on the resident’s reimbursement table. If there is no co-insurer specified on the reimbursement table, the remainder will be written off.
ANCILLARY PLANS

Passes a Percentage to Copayor

C001 Ancillaries
P018 Co-Pay - Ancillaries
W001 Ancillaries

This is normally used for a Medicare B plan or a plan that passes a percentage off to a copayor. This setup would be used on a Few type plan. It will charge revenue at the gross price. If there are Plan Items set up as Fee Schedule, then it will write-off the difference between gross charges and fee schedule amount and pass a percentage of the fee schedule amount to a co-payor. If there are Plan Items set up as Normal, then it will write-off the difference between the gross charge and reimbursement amount on the Plan Item and pass a percentage of the reimbursement amount to the co-payor. The percentage to be passed is on the P018 method.

Passes a Percentage to Copayor with Deductible

D001 Ancillaries
C001 Ancillaries
P018 Co-Pay - Ancillaries
W001 Ancillaries

This is normally used for a Medicare B plan or a plan that passes a percentage off to a copayor and there is also a deductible. This setup would be used on a Few type plan. It will charge revenue at the gross price and pass the deductible off to the co-payor. If there are Plan Items set up as Fee Schedule, then it will write-off the difference between gross charges and fee schedule amount and pass a percentage of the fee schedule amount to a co-payor. If there are Plan Items set up as Normal, then it will write-off the difference between the gross charge and reimbursement amount on the Plan Item and pass a percentage of the reimbursement amount to the co-payor. The percentage to be passed is on the P018 method.

No Coinsurance

C001 Ancillaries
W001 Ancillaries

This is normally used for a Medicare B plan or a plan that pays 100% of fee schedule or reimbursement amount. This setup would be used on a Few type plan. It will charge revenue at the gross price. If there are Plan Items set up as Fee Schedule, then it will write-off the difference between gross charges and fee schedule amount. If there are Plan Items set up as Normal, then it will write-off the difference between the gross charge and reimbursement amount on the Plan Item.
Percentage of Gross Charges with Remainder Written off

C003 Ancillaries
W001 Ancillaries

This is normally used for a plan that pays percentage of the reimbursement amount. This setup would be used on a Few type plan. It will charge revenue at the gross price. If there are Plan Items set up as Normal, then it will write-off the difference between the gross charge and reimbursement amount. The percentage is on the C003 method.
CO-INSURANCE PLANS

Co-insurance

C004  Co-Pay - Beds, Ancillaries

This is normally used for a plan that pays co-insurance. This setup would be used on a Most type plan. It will charge co-insurance at the full amount.

Write-off all Co-Insurance

W004  Co-Pay - Beds, Ancillaries

This is normally used for a plan that writes off co-insurance. This setup would be used on a Most type plan. It will accept and write-off the full amount of the co-insurance.

Percentage of Co-Insurance and Remainder written off

C044  Co-Pay - Beds, Ancillaries

This is normally used for a plan that pays a percentage of co-insurance. This setup would be used on a Most type plan. It will accept the full amount of the co-insurance and write off a percentage. The percentage is on the C044 method.

Percentage of Co-Insurance and Remainder passed off to Another Copayor

C004  Co-Pay - Beds, Ancillaries
P019  Co-Pay - Beds, Ancillaries

This is normally used for a plan that pays a percentage of co-insurance and the remainder can be passed off to another co-payor. This setup would be used on a Most type plan. It will charge co-insurance at the percentage amount and pass the remainder off to the co-payor entered on the co-insurance plan on the reimbursement table. The % is on the P019 method.
### General rules of setting up reimbursement tables:
These rules are based on the majority of skilled nursing clients, and specific rules and suggestions may not apply to your facility, based on your facility profiles, demographics and policies.

<table>
<thead>
<tr>
<th>1. Every resident in the facility must have a validated reimbursement table.</th>
<th>Once the table gets saved, the system will validate the table. If the validation fails, you must correct the table before you can produce a correct census or do billing. The table will still validate with some warnings (i.e. – “the plan date is before the residents’ admission date”), but all warnings should be investigated before trying to produce bills.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Every reimbursement table will have at least one private pay plan, and that private pay plan will always be the last plan on the reimbursement table.</td>
<td>Since private pay typically covers all levels and all dates, no other charges would get past Private Pay if it was at the top of the table.</td>
</tr>
<tr>
<td>3. If the resident qualifies for Medicare A, it will always be the 1st plan on the reimbursement table; immediately following Medicare A there should also be the Medicare A No Pay plan.</td>
<td>If the plan (such as Medicare A) requires a coinsurer and the co-insurer plan is NOT on the table, add the co-insurer plan to the reimbursement table first; in addition to adding it to the table; be sure to tie the co-insurance plan to the primary plan.</td>
</tr>
<tr>
<td>4. Except for plans that have either limited days (for example Medicare A) or dollars (for example some commercials plans), there should never be more than one occurrence of the same plan on any one table.</td>
<td>Select the “Show ALL” radio option at the top of the reimbursement table screen before adding any new plan to the table, so plan sequences are correctly maintained. You can use an existing sequence number and the system will “push down” any plans affected by this.</td>
</tr>
<tr>
<td>5. At least one plan must start with the date that the resident was admitted to the facility.</td>
<td>To end an existing plan on the reimbursement table: highlight the plan, select “Edit”, and enter the end date. Be mindful of retroactivity. Use a date in the current A/R period unless a prior date is necessary.</td>
</tr>
<tr>
<td>6. Once charges have been created for the resident, you cannot delete plans from the reimbursement table, nor should the order of the plans, or the dates attached to the plans be changed.</td>
<td>If this is done, retro will occur and the original charges will no longer be booked to the plan. Charges will book to the next payor on the table that covers the care level for the original plan’s period (typically Private Pay) or produce left over billworks.</td>
</tr>
</tbody>
</table>
### More Detailed Rules/Suggestions per Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Rules</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare A</td>
<td>• Always goes at the top of the reimbursement table.</td>
<td>Enter the plan start date.</td>
</tr>
<tr>
<td></td>
<td>• Requires a co-insurer.</td>
<td>Detail&gt; Enter from date and Co-insurer.</td>
</tr>
<tr>
<td></td>
<td>• Must attach a Qualifying Hospital Stay.</td>
<td>If you didn’t check “indicates a new spell of illness” when entering the hospital stay, then you won’t be able to attach the QHS.</td>
</tr>
<tr>
<td></td>
<td>• Indicate previous days used (if applicable).</td>
<td>Edit&gt; Days Used at Start</td>
</tr>
<tr>
<td></td>
<td>• Can have multiple Medicare A plans due to multiple Medicare A stays.</td>
<td></td>
</tr>
<tr>
<td>Medicare A No Pay</td>
<td>• Goes directly below Med A PPS</td>
<td>Enter the plan start date.</td>
</tr>
<tr>
<td></td>
<td>• Goes first on the table if Medicare Advantage</td>
<td>Enter the No Pay Status and Bill Method Override.</td>
</tr>
<tr>
<td></td>
<td>• No need to add new Medicare A No Pay plan for every new Medicare A PPS plan</td>
<td>The No Pay Status will be either blank or No Bill when receiving Medicare A benefits, then either Benefits Exhaust or No Pay depending on the residents cut situation.</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>• Goes below Medicare A No Pay and above all other primary payor plans on the reimbursement table</td>
<td>For Medicare Advantage Plans the No Pay Status will be Benefits Exhaust when the resident is receiving Medicare Advantage benefits, otherwise it will be No Pay.</td>
</tr>
<tr>
<td></td>
<td>• Could require a co-insurer.</td>
<td>Detail&gt; Enter from date and Co-insurer.</td>
</tr>
<tr>
<td></td>
<td>• If necessary, attach a Qualifying Hospital Stay.</td>
<td>If you didn’t check “indicates a new spell of illness” when entering the hospital stay, then you won’t be able to attach the QHS.</td>
</tr>
</tbody>
</table>

**NOTE:**
- End the original Medicare A Plan and insert a new plan if the resident DID NOT use the full 100 days on the original plan, had a break in the spell of illness, and has gone out to the hospital and been readmitted under Medicare Part A.
- To end the original plan, click on Edit and put in a plan end date.
- DO NOT delete or change the start date of the original plan – if this is done then retro will occur and the original Medicare A charges will no longer be booked as Medicare A but will book to the next payor on the reimbursement table that covered the care level for the original Medicare A period or be left over bill works.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Rules</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare B</td>
<td>• Goes above Medicaid and Private pay on the table.</td>
<td>Enter the plan start date.</td>
</tr>
<tr>
<td></td>
<td>• Requires a co-insurer.</td>
<td>Detail &gt; Enter from date and Co-insurer.</td>
</tr>
<tr>
<td></td>
<td>• If multiple visits, use the original Medicare B plan with the original plan start date</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:**
- DO NOT delete or change the start date of the original plan – if this is done then retro will occur and the original Medicare B charges will no longer be booked as Medicare B but will book to the next payor on the reimbursement table that covers the charges, or you could receive left over bill work errors when you calculate charges.
- If the co-insurer changes (i.e. had AARP and dropped it, so now has Medicaid for the co-insurer) go to Edit > Detail > enter the new from date, then go to the co-insurer field and enter the new co-insurer plan.
- Don’t forget to add the new coinsurer plan in the reimbursement table.

<table>
<thead>
<tr>
<th>Co-Insurance for Medicare A/B</th>
<th>• Put in reimbursement table below the Medicare A &amp; B plans, but above the Medicaid and Private Pay Plans.</th>
<th>Enter the plan start date. To enter policy information for commercial plans, click on Policy &gt; Enter Insured Information and Relationship to Patient, Enter Group Number, Policy Holder ID # and Group Name.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Might require a co-insurer depending on the plan.</td>
<td>Detail &gt; Enter from date and Co-insurer.</td>
</tr>
<tr>
<td></td>
<td>• If co-insurer is Medicaid a private pay portion may be needed depending on your state regulations.</td>
<td>Detail &gt; Enter Private Portion amount. (Don’t forget to put the Co-insurer in!)</td>
</tr>
</tbody>
</table>

**NOTE:**
- If the co-insurer changes, you will want to end the old co-insurance plan. To do this, click on Edit and enter the plan end date.
- Do not delete the old plan from the table or void it.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Rules</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Primary Insurance (Pays Room &amp; Board)</td>
<td>• Put in the reimbursement table above Private Pay, Medicaid.</td>
<td>Enter the effective start date.</td>
</tr>
<tr>
<td></td>
<td>• Enter the Reimbursement Rate for the resident if the plan process looks to the reimbursement table for the per diem rate.</td>
<td>Detail&gt; Enter from date, reimbursement rate, and indicate if day, month, year, etc.</td>
</tr>
<tr>
<td></td>
<td>• Enter the Coinsurance Rate for the resident if the plan process looks to the reimbursement table for the coinsurance rate.</td>
<td>Detail&gt; Enter from date, coinsurance rate, and indicate if day, month, year, etc.</td>
</tr>
<tr>
<td></td>
<td>• Enter Authorization information if required.</td>
<td>Detail&gt; Enter Auth # in Treatment Auth field and who authorized treatment in the Auth by field.</td>
</tr>
</tbody>
</table>

**NOTE:**
- If the resident no longer has access to benefits for a previous Commercial Primary Insurance put an end date on the plan in the reimbursement table. To do this, click on Edit and enter the plan end date.
- DO NOT delete the original plan if the resident is no longer eligible or has access to benefits – if this is done then retro will occur and the original charges will book to the next payor on the reimbursement table that covers the charges, or you could receive left over bill work errors when you calculate charges.

<table>
<thead>
<tr>
<th>Hospice</th>
<th>Put in table above Medicaid and Private Pay.</th>
<th>Enter the plan start date.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enter Patient Liability amount.</td>
<td>Detail&gt; Enter from date and Private Portion Amount.</td>
</tr>
<tr>
<td></td>
<td>Requires a Co-insurer. The co-insurer for Hospice will be a Private Resource/Patient Liability or Private Pay plan.</td>
<td>Detail&gt; Enter from date and enter Private Resource/Pay in the Co-insurer field.</td>
</tr>
</tbody>
</table>

**NOTE:**
- If the resident no longer has Hospice benefits, put an end date on the plan in the reimbursement table. To do this, click on Edit and enter the plan end date.
- DO NOT delete the original plan if the resident is no longer has Hospice benefits – if this is done then retro will occur and the original charges will book to the next payor on the reimbursement table that covers the charges, or you could receive left over bill work errors when you calculate charges.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Rules</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>• Put in table below Medicare, below Hospice and above Private Pay.</td>
<td>Enter the plan start date.</td>
</tr>
<tr>
<td></td>
<td>• Enter Patient Liability amount.</td>
<td>Detail&gt; Enter from date and Private Portion Amount.</td>
</tr>
<tr>
<td></td>
<td>• Requires a Co-insurer. The co-insurer for Medicaid will be a Private Resource/Patient Liability or Private Pay plan.</td>
<td>Detail&gt; Enter from date and enter Private Pay in the Co-insurer field.</td>
</tr>
</tbody>
</table>

**NOTE:**
- If the resident no longer is eligible for Medicaid, put an end date on the plan in the reimbursement table. To do this, click on Edit and enter the plan end date.
- DO NOT delete the original plan if the resident is no longer is eligible for Medicaid – if this is done then retro will occur and the original charges will book to the next payor on the reimbursement table that covers the charges, or you could receive left over bill work errors when you calculate charges.
- You could have multiple Medicaid plans on a reimbursement table if the resident had a break in their eligibility.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Resource/Patient Liability</td>
<td>• Goes on the table below the Hospice/Medicaid plans</td>
</tr>
<tr>
<td>Private Pay</td>
<td>• Always the last plan on the reimbursement table.</td>
</tr>
</tbody>
</table>
### Medicare A Primary Payor with Commercial Coinsurance, Private Pay Primary after Medicare A benefits end

<table>
<thead>
<tr>
<th>Seq.</th>
<th>Plan</th>
<th>Coinsurer (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Medicare A</td>
<td>AARP Part A Coinsurance</td>
</tr>
<tr>
<td>20</td>
<td>Medicare A No Pay</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Medicare B</td>
<td>AARP Part B Coinsurance</td>
</tr>
<tr>
<td>40</td>
<td>AARP Part A Coinsurance</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>AARP Part B Coinsurance</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Private Pay</td>
<td></td>
</tr>
</tbody>
</table>

### Medicare A Primary Payor with Medicaid Coinsurance, Medicaid Primary after Medicare A Benefits end

<table>
<thead>
<tr>
<th>Seq.</th>
<th>Plan</th>
<th>Coinsurer (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Medicare A</td>
<td>Medicaid Part A Coinsurance</td>
</tr>
<tr>
<td>20</td>
<td>Medicare A No Pay</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Medicare B</td>
<td>Medicaid Part B Coinsurance</td>
</tr>
<tr>
<td>40</td>
<td>Medicaid Part A Coinsurance</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Medicaid Part B Coinsurance</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Medicaid</td>
<td>Patient Liability</td>
</tr>
<tr>
<td>70</td>
<td>Patient Liability</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>Private Pay</td>
<td></td>
</tr>
</tbody>
</table>

### Private Pay Primary Payor with Medicare B and Commercial Coinsurance

<table>
<thead>
<tr>
<th>Seq.</th>
<th>Plan</th>
<th>Coinsurer (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Medicare B</td>
<td>AARP Part B Coinsurance</td>
</tr>
<tr>
<td>20</td>
<td>AARP Part B Coinsurance</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Private Pay</td>
<td></td>
</tr>
</tbody>
</table>

### Private Pay Primary Payor with Medicare B and Private Pay is the Coinsurer

<table>
<thead>
<tr>
<th>Seq.</th>
<th>Plan</th>
<th>Coinsurer (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Medicare B</td>
<td>Private Pay</td>
</tr>
<tr>
<td>20</td>
<td>Private Pay</td>
<td></td>
</tr>
</tbody>
</table>

### Hospice Primary Payor with Medicare B

<table>
<thead>
<tr>
<th>Seq.</th>
<th>Plan</th>
<th>Coinsurer (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Medicare B</td>
<td>Private Pay</td>
</tr>
<tr>
<td>20</td>
<td>Hospice</td>
<td>Patient Liability</td>
</tr>
<tr>
<td>30</td>
<td>Patient Liability</td>
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DEFAULT REIMBURSEMENT TABLES

Default Reimbursement Tables are basically templates of a reimbursement table setup. You can set up templates of common payor combinations that residents will have. Then when you admit a resident, you choose the default table that matches their available payors. The default table plans will be added to the resident, with the co-insurers already attached to the primary plans. You can then modify, add, or delete plans from the table you’ve added. Note: Once you have a reimbursement table on a resident, you never want to add another entire default table.

To add a default reimbursement table:

2. In the Add/Modify field, type the name for the default table. Make the name as descriptive as possible – this is the only name seen when selecting a default table to add.
3. Click the Save icon.
4. Highlight the default reimbursement table you just entered/modified and click Edit.
5. Select the plan, adding the sequence order that they should appear on the table.

        NOTE: Be sure to identify the sequence number of a co-insurer if applicable.

6. Click Save.
7. Enter the next plan, and continue until you have all the plans added for the table.
8. Click Cancel to return to the Add/Modify field.